DERP Denver Employees Retirement Plan

Powering Your Future, Together.

2025 Health Insurance Election Form

Complete this form if...	Form Submission Deadline	Benefits Effective Date
1. **You're a new retiree**	Within 30 days of your retirement date	Your retirement date
2. **You've experienced a qualifying life event in the past 30 days**	Within 30 days after your event	The first of the month after your event

You must submit proof of dependency along with your Health Insurance Election Form.

- ✓ If you're covering your spouse, a marriage certificate or common law affidavit is required.
- ✓ If you're covering your child(ren) a certified birth certificate or Letters of Guardianship is required.
- ✓ When you've experienced a qualifying life event, you must submit proof of the event.

Refer to the 2025 DERP Retiree Health Insurance Guide to select the benefits that are right for you and your dependents.

Step 1 – Provide Your Information (All fields must be populated.)

Name (First, Middle Initial, Last) _____

DERP ID (call DERP if you don't know your ID) _____

Address and/or P.O. Box, City, State, Zip Code _____

Personal Email Address _____

Personal Phone Number _____

Step 2 – Tell Us Why You're Completing This Form

☐ **I am a new retiree**

My retirement date is: _____

☐ **I've had a qualifying life event**

Date of my qualifying life event is: _____

Select the qualifying life event and attach proof of the event

☐ Eligible for Medicare
☐ Moved out of service area
☐ Change in marital status
☐ Involuntary loss of health insurance

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Step 3 – Select a Non-Medicare Medical Plan and/or a Medicare Advantage Medical Plan for Yourself and/or Your Dependents

You can choose a mix of non-Medicare and/or a Medicare Advantage medical plan(s).

Non-Medicare Medical Plans

✓ Available to you and/or your dependents under age 65.
Eligible dependents include:
- Your spouse
- Your child(ren) to age 26

✓ Everyone under age 65 must be enrolled in the same plan.

Medicare Advantage Medical Plans

✓ Available to you and/or your dependents who are Medicare eligible due to age (65) or disability (any age).
Eligible dependents include:
- Your spouse
- Your dependent child(ren) physically or mentally unable to care for themselves

✓ Includes Part D, Prescription Drug Coverage. Do not enroll in a separate Part D plan as this will cause you and/or your dependent to be cancelled from the DERP Medicare Advantage

✓ You and your dependents can select different plans.

✓ You must provide a copy of Medicare card(s) for each person enrolled.

✓ A signature is required for each person enrolled.

Populate this table for yourself and each dependent.

Relation	Name (First, Middle Initial, Last)	Gender	Birth Date	SSN	Non-Medicare Medical					Medicare Advantage Medical		
					Kaiser		United HealthCare			Kaiser	Humana	
					HDHP	DHMO	HDHP	CDP	Denver Health PPO	Colorado HMO	HMO	PPO
Self		M F										
Spouse		M F										
Child		M F										
Child		M F										
Child		M F										

Did you or your dependents enroll in a Medicare Advantage Medical Plan?

If so, each person enrolled in a Medicare Advantage Medical Plan must acknowledge their enrollment with their signature in the table below.

Relation	Member / Dependent Signature (First, Middle Initial, Last)	Date
Self		
Spouse		
Child		
Child		
Child		

Did you or your dependents enroll in UnitedHealthcare (UHC) CDP or Humana HMO plan?

If so, you must select a Primary Care Physician (PCP) for each person enrolled. If you do not select a PCP, one will be assigned based on your address.

Member / Dependent Name (First, Middle Initial, Last)	PCP Name	UHC or Humana HMO Provider ID

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Step 4 – Select Your Dental Plan

Populate this table for yourself and each dependent. Everyone must be enrolled in the same plan.

Relation	Name (First, Middle Initial, Last)	Gender	Birth Date	SSN	Cigna			Delta		
					DHMO*	PPO High	PPO Low	EPO	PPO High	PPO Low
Self		M F								
Spouse		M F								
Child		M F								
Child		M F								
Child		M F								

***Did you enroll in the Cigna DHMO election?**

If so, you must choose a dentist and enter the Provider Code below for yourself and/or your dependents. Provider codes can be found on the Cigna website (cigna.com) or by calling Cigna Dental (1-800-244-6224).

Relation	Name (First, Middle Initial, Last)	PCP Name	Provider ID
Self			
Spouse			
Child			
Child			
Child			

Step 5 – Select Your Vision Plan

DERP offers one vision plan with VSP.
Do you want to enroll in VSP?

☐ **Yes**, I want to enroll in VSP for myself and/or my dependents.

☐ **No**, I do not want to enroll in VSP for myself or my dependents.

Populate this table for yourself and each dependent enrolled in VSP.

Relation	Name (First, Middle Initial, Last)	Gender	Birth Date	SSN
Self		M F		
Spouse		M F		
Child		M F		
Child		M F		
Child		M F		

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Step 6 – Certification

Your Health Insurance Election Form will not be processed if your form is not signed. Electronic signatures are not accepted.

By signing this form, I certify and agree with the following statements:

- ✓ I certify the information I provided on this form is accurate.
- ✓ I attest I have reviewed the insurance information and the elections I have made are correct.
- ✓ I understand I cannot change my health insurance election for myself and/or my dependents until the next Open Enrollment period unless I have a qualifying life event.
- ✓ I affirm I am eligible to enroll in the health insurance offered through DERP, and if I am enrolling my spouse and/or dependents, I affirm they are eligible to be enrolled.
- ✓ I understand my health insurance deductions are post-tax and deducted from my monthly DERP Pension Benefit payment.
- ✓ I understand if my health insurance deductions are more than my monthly DERP Pension Benefit payment, I am required to complete and submit a Direct Withdrawal Authorization form to have the remaining amount deducted each month from my preferred bank account.
- ✓ I understand it is my responsibility to notify DERP of any changes in the eligibility of myself, my spouse, and/or my dependents and DERP is not responsible for informing me of my rights, benefits, and services under the selected insurance provider.
- ✓ I understand I must complete and submit to DERP, the Health Insurance Disenrollment Form 30 days before I wish to cancel this coverage.

Member Signature _____ Date _____

Step 7 – Submit Your Health Insurance Election Form

You can email, fax, or mail your completed and signed form:

- ✓ Email Help@DERP.org
- ✓ Fax (303) 839-9525
- ✓ Mail to 777 Pearl St, Denver CO 80203

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